

Birmingham

Local system review report Health and Wellbeing Board

Date of review:
22 – 26 January 2018

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and Social Care and for Housing, Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:
Delivery Lead: Ann Ford, CQC
Lead reviewer: Wendy Dixon, CQC

The team included:

- CQC System Reviewer
- CQC Chief Executive
- CQC Deputy Chief Inspector
- CQC Director of Engagement
- CQC Inspection Manager and Inspectors
- CQC Strategy Manager
- CQC Analyst
- Four Specialist Advisors; one former Director of Adult Social Services, two current local authority Chief Executives and two Clinical Commissioning Group Board members.

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interface between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Birmingham City Council (the local authority), NHS Birmingham CrossCity, NHS Birmingham South and Central, and NHS Sandwell and West Birmingham Clinical Commissioning Groups (referred to collectively in this report as the CCGs), the Health and Wellbeing Board (the HWB), Birmingham City Council's Overview and Scrutiny Committee and elected leaders
- System leaders from University Hospitals Birmingham NHS Foundation Trust (UHB), Birmingham Community Healthcare NHS Foundation Trust (BCHT), West Midlands Ambulance Service NHS Foundation Trust (WMAS), Heart of England NHS Foundation Trust (HoEFT), Sandwell and West Birmingham Hospitals NHS Trust (SWBH), and Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT)
- Health and social care professionals including social workers, GPs, pharmacy leads, discharge teams, therapists, nurses and commissioners
- Healthwatch Birmingham and voluntary, community and social enterprise (VCSE) sector organisations
- Providers of residential, nursing and domiciliary care
- People who use services, their families and carers who attended focus groups. We also spoke with people in A&E, hospital wards and at residential and intermediate care facilities.

We reviewed 34 care and treatment records and visited 17 services in the local area including acute hospitals, intermediate care facilities, residential and nursing homes and GP practices.

The Birmingham context

Demographics

- 13% of the population is aged 65 and over.
- 58% of the population identifies as white.
- Birmingham is in the 20% most deprived local authorities in England.

Adult social care

- 88 active residential care homes:
 - One rated outstanding
 - 42 rated good
 - 29 rated requires improvement
 - Four rated inadequate
 - 12 currently unrated
- 41 active nursing care homes:
 - 18 rated good
 - 14 rated requires improvement
 - One rated inadequate
 - Eight currently unrated
- 70 active domiciliary care agencies:
 - 38 rated good
 - 18 rated requires improvement
 - 14 currently unrated

GP Practices

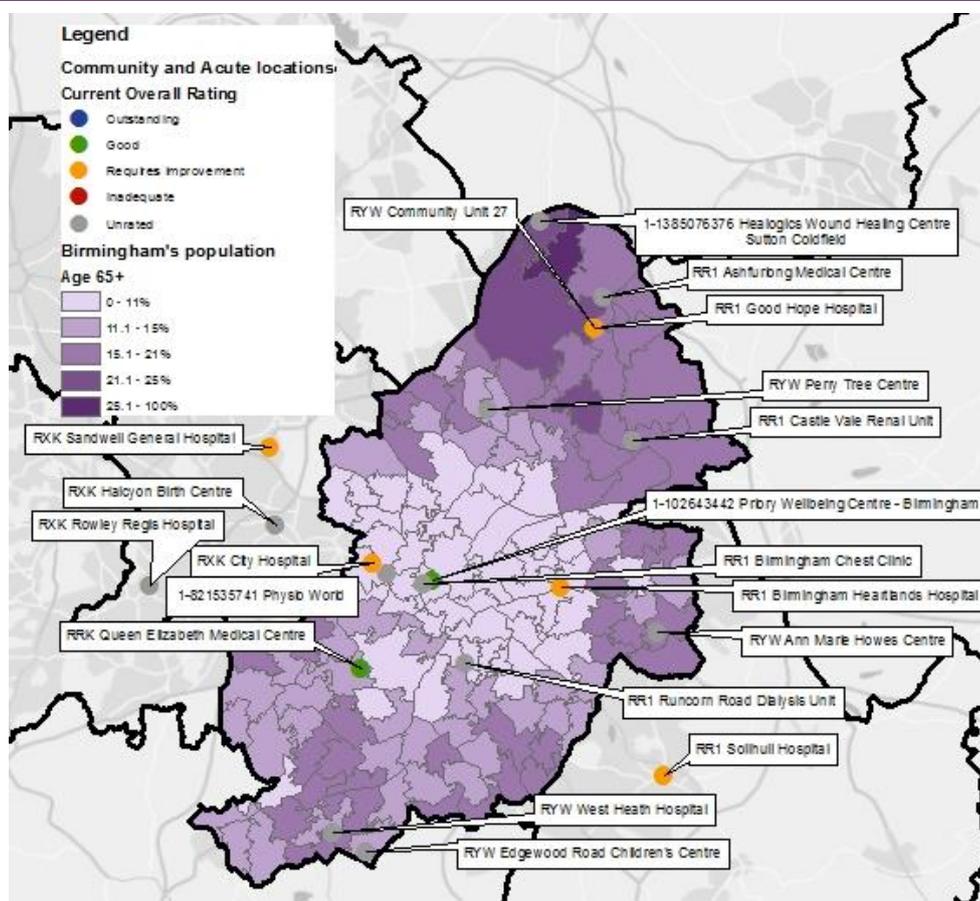
- 194 active locations
 - Two rated outstanding
 - 130 rated good
 - 14 rated requires improvement
 - Two rated inadequate
 - 46 currently unrated

Acute and community healthcare

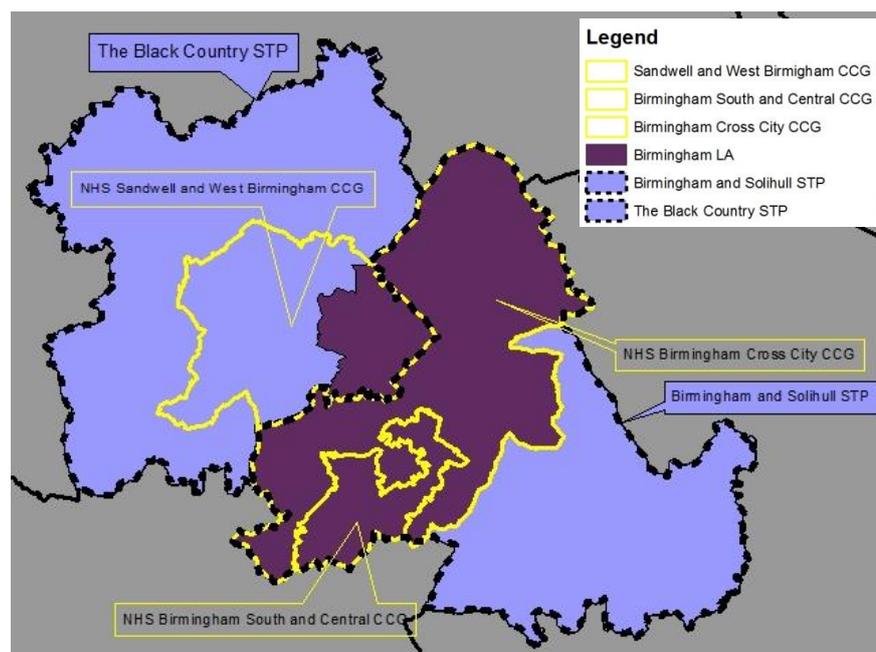
Hospital admissions (elective and non-elective) of people living in Birmingham are found at the following trusts:

- Heart of England NHS Foundation Trust
 - Received 50% of admissions of people living in Birmingham
 - Admissions from Birmingham made up 55% of the trust's total admission activity
 - Rated requires improvement overall
- University Hospitals Birmingham NHS Foundation Trust
 - Received 29% of admissions of people living in Birmingham
 - Admissions from Birmingham made up 67% of the trust's total admission activity
 - Rated good overall
- Sandwell and West Birmingham Hospitals NHS Trust
 - Received 18% of admissions of people living in Birmingham
 - Admissions from Birmingham made up 41% of the trust's total admission activity
 - Rated requires improvement overall
- Community services are provided by Birmingham Community Healthcare NHS Foundation Trust
 - Rated Good overall

All location ratings as at 08/12/2017. Admissions percentages from 2016/17 Hospital Episode Statistics.



Map 1: Population of Birmingham shaded by proportion aged 65+ and location and current rating of acute and community NHS healthcare organisations serving Birmingham.



Map 2: Location of Birmingham LA within Birmingham and Solihull STP and The Black Country STP.

Sandwell and West Birmingham, Birmingham South and Central and Birmingham CrossCity CCGs are also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- Birmingham was in the embryonic stages of integration, but considering there had been no history, culture or tradition of joint working, the recent improvements and renewed motivation was significant step forward for the system.
- The city of Birmingham sat within two Sustainability and Transformation Plans (STPs). Both were aligned in their vision, but this had not been translated into a local deliverable plan for Birmingham.
- While there was a shared vision for community, place-based care, this had not been developed into a single, coherent strategy for Birmingham which could be clearly articulated by middle management and frontline staff. There was not a shared use of language by system leaders to describe the strategic direction for the future, demonstrating plans were at an early stage of development and often remained at organisational level. Although plans had been agreed to move to community, place-based care within defined geographical areas, the boundaries had only been agreed the week before our review.
- There was not an up-to-date, coherent, shared view of the needs of Birmingham's population. Although there was a Joint Strategic Needs Assessment (JSNA), it was not clear how the priorities identified were being used to inform future commissioning intentions. Furthermore, no annual public health report had been published for at least two years, which was a failure to meet a statutory obligation. Therefore, we could not be assured the system was looking at the needs of the population in order to plan and deliver services to address the high levels of deprivation and significant variation in life expectancy.

Is there a clear framework for interagency collaboration?

- There was not a clear framework for interagency collaboration. It was widely acknowledged that relationships had been challenging in the past and a barrier to change. Recent changes in the system, including a renewed focus on adult social care in the local authority and new senior appointments across the system, had created a renewed sense of motivation which was a positive step. However, some posts were interim and consequently the system needs to ensure there is stability in the leadership to manage the necessary changes.

- There had been a renewed focus within the Birmingham Solihull STP with a change of leadership and recognition of the need to look at the whole system. This was a positive step, but leaders need to ensure delivery takes a whole system approach and is not focussed solely on the acute sector or with an over-reliance on bed based care.
- There were considerable levels of innovative work going on within the primary care sector, where services were being delivered at scale. This provided an opportunity to drive integration through primary care and system leaders need to ensure they harness this potential.
- Aside from the Better Care Fund (BCF), there were no other examples of pooled budgets in place for the delivery of services across the health and social care interface in relation to older people. Although there was a will to work together and examples of collaborative working at a system level, there were no truly integrated commissioning arrangements or joint commissioning strategies at the time of our review.
- Governance arrangements had an organisational rather than system focus. While individual organisations had robust risk management processes in place and a shared view of system-level risks was emerging, there was not a single, coherent risk register for the system. Birmingham faced significant financial pressures (including a 30% reduction in the social care budget), but there was no real sense of this being considered a shared risk between health and social care.

How are interagency processes delivered?

- The challenge for this system was to transform services while also delivering improvements in performance. The joint commissioning of an external review into pathways through the system was a sign of developing trust between partners. The next step will be to work collaboratively to deliver its recommendations.
- The Birmingham and Solihull STP Board (covering 80% of the city) had recently undergone a change in leadership. Birmingham system partners were unanimously positive about this change and the STP Board had taken on a system leadership role within the city. This was a positive step forward, but the statutory obligation of the Health and Wellbeing Board (HWB) was not being fully met; it was not taking a proactive approach, nor holding the system to account on behalf of the people of Birmingham. The relationship between the STP and the HWB needs to be reviewed and strengthened to ensure there is clarity around each other's roles and responsibilities.
- There were some good examples of multidisciplinary working within parts of the system, but these were often the result of siloed, innovative practices set up by individual teams

or providers, such as the primary care vanguard. This led to fragmentation and inequity in service provision as areas of good practice had not been rolled out across the system.

- Some recent changes to frontline delivery (such as hospital-based integrated discharge teams) had led to improvements and it was hoped the diagnostic report from the external review would be a further driver for change and improvement. However, at the time of our review service delivery remained fragmented. Although staff expressed a will to work more collaboratively, the confusing and complex landscape was a barrier to achieving this.
- Mechanisms to engage with wider system partners, including providers and voluntary, community and social enterprise (VCSE) sector organisations needed to be strengthened. At the time of our review, there was limited evidence to demonstrate how VCSE organisations were involved in developing strategic commissioning intentions to date and those we spoke with felt they were underutilised. It was widely recognised by system leaders that they needed to work more proactively with the VCSE sector and in November 2017 Birmingham City Council's cabinet had signed off '*Putting Prevention First: Supporting the Implementation of the Vision for Adult Social Care and Health*'. This report outlined a commitment by the local authority to invest in targeted prevention and the development of community assets and a Neighbourhood Networks Service.

What are the experiences of frontline staff?

- Frontline staff we met with were committed to delivering high quality and person-centred care, but they were demoralised by the persistent challenging working conditions and there was a risk of them becoming burnt-out. They were aware of the scale of the challenges in the system and were optimistic that the recent changes in system leadership and refocusing of efforts would lead to a more joined up way of working. However, at the time of our review, they felt there was still a long way to go.
- Staff were not able to articulate a system-wide vision. Staff reported that they were beginning to see the emergence of shared goals and objectives, however as there was not yet a shared strategic vision for the system, they were not clear about who was accountable for delivering them.
- We found examples of staff working well in an integrated way to improve outcomes for people, such as through multidisciplinary discharge teams. However, fragmentation of services and structural barriers prevented staff from communicating effectively with one another. Staff on the front line were working towards their own organisation's budgets and targets which also created barriers to integrated working.

- Staff reported that pathways of care could be complex and they did not always know the best place to refer people to. Care home and nursing home staff were not aware that they could refer into the community single point of access. There were pockets of collaborative working between primary care and the VCSE sector; however across the city there was scope for closer working between these services to provide care that was person-centred rather than service-driven.
- Staff throughout the system reported that information sharing across the health and social care interface needed to improve and this was described as a key barrier to integrated working and improving outcomes for people. Although 1.1 million people had opted in to Your Care Connected, which aimed to give secondary care providers access to people's GP records and allowed people to access their own health records, this was not being used effectively by staff in secondary care at the time of our review.

What are the experiences of people who use services?

- The experiences of people receiving health and social care services in Birmingham varied. Access and availability of services was inconsistent across the city. The system was large and complex which made it difficult for people to navigate.
- There was a dedicated VCSE sector that provided older people and carers with support, information and advice. There were opportunities in parts of the city for people to be involved in schemes that supported them to be socially engaged and involved in their community.
- The number of people receiving personal budgets and direct payments was low. This meant that fewer people had the chance to exercise choice and control over their care and support. People could have limited choice in their care and some were offered care placements in parts of the city that were not accessible to their families.
- Some people who experienced a crisis and attended A&E were admitted to hospital with social care needs that could have been managed more effectively and safely at home. One person we met during our review had been waiting a considerable length of time in A&E for transport to take them home; this meant that the person was discharged late at night and was vulnerable as they lived alone.
- People's experience of being discharged from hospital was not always person-centred. Some people stayed in hospital for longer than they needed to and received multiple assessments from different professionals. It was widely recognised that the continuing healthcare (CHC) processes were not working as effectively as they should for people in terms of timeliness and communication with them, their families and carers. Work had begun to improve performance in this regard.

- There was not a systematic and joined up approach across the city to using feedback from people, their families and carers, and public insight in the development of strategy and services. More could be done to engage Birmingham’s diverse communities (nearly 40 % identified as being from Black, Asian and Minority Ethnic (BME) populations) in the planning and delivery of services to ensure that they meet the specific cultural and health needs of local populations.

Are services in Birmingham well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interfaces to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interfaces of health and social care for people over 65. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.

Birmingham’s health and social care landscape is complex with multiple providers, commissioning bodies and two Sustainability and Transformation Plan footprints. Although the STPs provided a strategic vision for the wider geographical area, the health and wellbeing of people who lived in Birmingham was placed at risk by the lack of a clear and compelling single strategy and deliverable plan. While there was a recently agreed shared view that place-based integrated care was the correct direction of travel, there was a lack of consensus about how this would be delivered in practice.

Historically relationships had been challenging with a lack of partnership working. Recent changes within the system’s leadership had created better relationships and conditions more receptive to positive change. Changes to organisational structures such as CCG mergers and provider mergers were seen as opportunities to overcome historical barriers to integrated working. However, several key leadership posts were interim and in order for transformational changes to embed and lead to system wide improvements there needs to be a period of continuity and stability in the system’s leadership.

Strategy, vision and partnership working

- System leaders acknowledged that effective partnership working was integral to improving health and wellbeing outcomes for the people of Birmingham. Historically relationships had been poor with competitive behaviours between organisations. The system leaders that we spoke to were open in their view that this had led to siloed working and a fragmented system with sub-optimal performance. There had been some recent changes

to the system leadership and planned changes to organisational structures; relationships were reported to be significantly improving as a result. However, several key appointments were interim, which did not provide stability in the leadership to embed any transformational changes and ensure any improvements were sustained.

- From April 2018, the three CCGs covering 78% of the population (NHS Birmingham CrossCity Clinical Commissioning Group, NHS Birmingham South Central Clinical Commissioning Group, and NHS Solihull Clinical Commissioning Group) will merge to create a single commissioning body, aligned with the footprint of the Birmingham and Solihull (BSol) STP. Sandwell and West Birmingham CCG, sitting within Black Country and West Birmingham STP will have associate membership of BSol and an agreed approach for working with the merged CCG through a memorandum of understanding.
- These new organisational arrangements were welcomed by the leaders, frontline staff and stakeholders we interviewed as part of our review. It was widely anticipated these changes would enable the system to overcome the fragmentation which had been a barrier to partnership working in the past. Some comments provided through the relational audit (responded to by only 59 people) similarly identified improvements in terms of shared vision and joint working, with organisations beginning to understand each other's issues and priorities, and work towards common aims. However, other responses, particularly from social care providers, indicated there was still a perceived lack of engagement and transparency from the local authority. A marker of Birmingham's progress towards more collaborative working was the joint commissioning in November 2017 of an independent review of how older people move through the system - the Recovery, Rehabilitation and Reablement review undertaken by an external consultancy firm. This gave a comprehensive diagnostic analysis and it will be important for system partners to work together to deliver the recommendations made.
- The Birmingham commissioning landscape is complex with multiple partners involved in a large geographical footprint. The city sits across two Sustainability and Transformation Plan (STP) footprints and three clinical commissioning groups (NHS Birmingham CrossCity, NHS Birmingham South and Central and NHS Solihull CCGs), with borders and patient flows through a fourth (NHS Sandwell and West Birmingham CCG). Around 80% of the population were included in the footprint of the Birmingham Solihull STP and 20% in the Black Country and West Birmingham STP. This presented a challenge for the system. Although there was a memorandum of understanding between the two STPs, Black Country and West Birmingham needs to ensure its voice is heard within the wider Birmingham system to ensure any changes reflect the needs of the population it serves.
- The strategic visions for the two STPs covering the city of Birmingham were aligned. However, this had not been translated to the local level and there was not yet a clearly

articulated strategy for future service delivery. While there was a high-level, emergent vision to provide place-based care within localities or 'constituencies', this was yet to be delivered in practice, or to be articulated in a clear delivery plan.

- The concept of constituencies as vehicles for integrated delivery of health and social care had been led by the local authority and its view of how community social care teams should be geographically arranged. Birmingham Community Healthcare NHS Foundation Trust (BCHT) was aligned to the strategic vision and was developing a service model of multidisciplinary teams working with primary and social care to provide wrap care around a person within the community setting. The merged CCG that would be forming in April 2018 was working in shadow form at the time of our review and was in the process of developing an integration work stream and community care strategy. In our discussions with GPs, there was general support for a place-based approach, and the potential to deliver multidisciplinary team working around practice lists was welcomed. However, this was still at a very early stage of development and we received mixed messages about the involvement of the wider GP body in the defining of the local delivery populations and, more specifically, how the more localised wards within the localities would be arranged. Indeed, the boundaries had only been agreed by the CCG in the week before our review.
- A winter plan coordinated by the CCGs, had been signed off by the A&E Delivery Board. This included weekly system meetings to review performance and plan ahead. While the plan incorporated actions for all partners, it was not always understood or widely known about at an operational level. Primary and social care providers we spoke with had been asked for information by commissioners to contribute to the plan, but had not always seen the output. Furthermore, some system partners felt there had been a reactive, bed-based response to winter. In response, system leaders told us there was an expectation for additional national funding that had been made available prior to winter be used to increase acute bed capacity. In January 2018, 13 consultant-led virtual beds had been established in the community to support winter resilience. BCHT supported the acute trusts to identify those who were safe for therapy in the community rather than just being 'medically fit'.

Involvement of people who use services, families and carers in the development of strategy and services

- There was not a systematic and joined up approach across the city to using feedback from people, their families and carers, and public insight in the development of strategy and services. Birmingham had a large and active voluntary sector which was actively involved in public engagement. The Ageing Better Programme for example, delivered by Birmingham Voluntary Services Council (BVSC) and funded by The Big Lottery, demonstrated effective engagement with the public in the development of Ageing Better Hubs to support older people to be less isolated and more engaged in the community.

- Healthwatch Birmingham was identified as a system partner holding oversight for best practice engagement across the city and was well engaged by the local authority and CCGs. Healthwatch Birmingham was supporting the development of a more joined up approach to engagement with people using services, carers and the general public. In partnership with NHS England they had developed a Quality Standard for using patient and public insight, experience and involvement to reduce health inequality. They were reviewing practice across the CrossCity CCG and South and Central CCGs against the Quality Standard, with a view to establishing a preferred model of engagement when the CCGs merge. However, there is a risk in placing an over-reliance on an organisation with limited capacity and a need for this work to be driven more widely across the system. Following our review, we were informed that the CCGs had received Healthwatch Birmingham's report in March 2018 and that the subsequent implementation and delivery of the recommendations was the responsibility of the CCGs' communications and engagement team.
- Although there were individual examples of public engagement, these were often at service or organisational level. Greater consideration is needed about how public engagement and involvement can be achieved at a larger scale in a way that is inclusive to all. Some people told us there was a tendency to rely on web-based feedback. For example, citizen events were held to consult people on the new adult social care framework which outlined an intent to include peoples' feedback in the way social care services are rated. However, the framework did not provide any detail about how this would be facilitated other than including a web-based link to Birmingham Healthwatch.
- The local authority had a long established and effective Citizen's Panel as a forum for co-production. Citizens Panel members felt genuinely empowered in their role, and could evidence their influence on strategic and commissioning decisions. This panel was not however directly concerned with services for older people.
- It was widely recognised by system leaders that engagement and involvement in strategic planning was a priority. They demonstrated a commitment to delivering change; they had taken the innovative step to commission a theatre group to facilitate discussions with frontline staff about why and how change should happen. The performance by the theatre group, entitled 'Phyllis', described a person's experience of health and social care based on engagement and research with staff, carers and people who use services. The aim was to raise awareness and encourage discussions among staff about how change should be delivered. System leaders need to build on this, ensuring the future health and social care landscape of Birmingham is co-produced and reflects the needs and diversity of the local population. Birmingham had high levels of deprivation (much of the city was in

the top 20% of most deprived areas) and high levels of diversity with approximately 40% of the population identifying as Black, Asian or Minority Ethnic (BAME).

Promoting a culture of interagency and multidisciplinary working

- Not only was there no clear framework, there was no history, culture or tradition of joint working or interagency collaboration across the health and social care interface. System leaders acknowledged that support services and commissioning had historically been fragmented in Birmingham, leading to poor experiences and outcomes for people. While there was a drive towards greater interagency and multidisciplinary working, in practice it was embryonic. A joint working commitment for the BSol STP was in draft form at the time of our review.
- While relationships were improving at the system leadership level, the impact of the changes was not apparent within second and third tier management or on the front line at the time of our review. Frontline staff we spoke to across the system reported that there was a lack of integrated working between health and social care. The Recovery, Rehabilitation and Reablement review commissioned by the system and completed in January 2018 highlighted that staff found working across organisations difficult.
- During the course of our review staff told us recent system changes were beginning to lead to improvements and there was renewed sense of motivation. All staff we spoke with expressed a will to work more collaboratively, but there was uncertainty and a lack of awareness among some about how this would be facilitated by future plans. We saw several examples of where individual staff and groups were already working in innovative ways. The system needs to ensure there is a comprehensive evaluation of current services and ways of working throughout the city before wholesale changes are made which could demotivate staff and destabilise existing integrated working.
- While we found some examples of effective multidisciplinary working, it was not system-wide. Even where there were examples of multidisciplinary working between community health teams and primary care, these were often without input from adult social care.
- In parts of the city there was fragmentation both operationally and culturally, which was impacting on peoples' experiences. Often this was a result of ineffective communication or a lack of clarity around roles and responsibilities. For example, the enhanced assessment unit (Community Unit 27) delivered by BCHAT aimed to facilitate timely discharges. It was based on the same site as Good Hope Hospital (HoEFT), so people could be discharged directly from the acute site to the assessment unit. However, we found examples of people waiting for considerable lengths of time in the acute hospital discharge lounge for their medicines; rather than staff asking pharmacy to deliver this to CU27 directly, people

experienced unnecessary delays which put them at risk of avoidable harm and was a poor experience.

Learning and improvement across the system

- In the response to the SOIR, system leaders acknowledged that there had historically been a fragmented, individualistic approach to learning and improving, based within rather than across organisations. With the use of Better Care Fund monies, the recent joint commissioning of the Recovery, Rehabilitation and Reablement review to provide a diagnosis on the reasons for continued system flow issues was a sign of a more collaborative commitment to system improvement. There was a shared acceptance among system leaders of the review's findings, but there was some scepticism about how they would be able to implement the changes needed based on current system challenges and historical relationship challenges. Furthermore, GP federations reported they had not been invited to be involved in the review until the last minute, demonstrating a focus on the acute setting rather than the entire urgent care pathway.
- The response to the SOIR stated there were examples of innovation and good practice within individual organisations, but the system had been less successful at implementing this at a larger scale. This was supported by the findings of our review. For example, we found examples of innovative practice within primary care looking at new ways of working to ensure service delivery met the needs of local populations. However, there had been a lack of engagement with the CCG to share the positive outcomes and reduce inequity in service delivery across the city.
- Stakeholders had also identified a disjointed approach to learning and improvement across the system. Healthwatch Birmingham had been supporting NHS England in its assurance reviews of the Birmingham CCGs and identified a common gap across them in having a systematic approach to evaluation and learning from feedback. Healthwatch Birmingham investigated the CCG complaints system and will monitor the agreed actions throughout 2018. They were also investigating direct payments for social care. Their report would help to inform the local authority's strategy for increasing access to, and use of, direct payments. Data for Birmingham showed fewer people received direct payments than comparator or national averages (in 2016/17 11.3% of older people using social care services in Birmingham received direct payments, compared to 17.6% nationally and 17.1% across comparator areas).

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

Governance arrangements were traditional, with an organisational rather than system focus. Individual organisations had their own robust governance arrangements, but there was no shared view of risks and mitigating actions, and no formal risk-sharing agreements in place. Neither Birmingham system nor the STPs held a shared risk register so system leaders were unable to appraise and assure themselves of risks across the health and social care interface. Data used to monitor flow was based on traditional performance indicators rather than outcomes for people.

While there was clear intent by system leaders to share information to provide seamless pathways of care, a lack of integrated records systems was a barrier to this.

Overarching governance arrangements

- Governance arrangements were based at organisational level and there was a lack of strong, system-level governance structures or agreed governance frameworks in place across the health and social care interface. Individual organisations had a good assurance of their own performance, but objectives were linked to their individual priorities rather than a shared, system approach.
- System-level governance arrangements were embryonic and not yet embedded. The response to the SOIR stated that a 'Joint Working Commitment' was in draft and an STP Memorandum of Understanding was in the process of being agreed by partners. The proposed governance structures reflected STP agreements with three groups reporting to the STP Boards: Urgent and Emergency Care, Primary Care Development and Integrated Place Programme. The BCF Commissioning Executive was also described as playing a key role. The proposed governance structures looked complex and it will be important that partners have a shared understanding and agree with them.
- It was clear that the Birmingham and Solihull STP had brought a new impetus to the city. Indeed, system leaders described the STP Board as the vehicle for taking forward the transformation for the city rather than a Birmingham-focused delivery structure. The Health and Wellbeing Board, with the statutory function for providing oversight and assurance of Birmingham's health and social care system, acted more as a council committee and was a passive recipient of information rather than using its role to exert influence in the wider system. The Overview and Scrutiny Committee provided a higher level of challenge than the HWB. It was clear that through the work of the STP the vision for Birmingham would be taken forward and in doing this it will be essential for the HWB function to be reviewed and strengthened to ensure there is system-level leadership, assurance and accountability.

- System partners acknowledged that multiple pathways of care continued to present a challenge and required additional work in terms of governance arrangements as well as future contracting and commissioning arrangements. The commissioning of the Recovery, Rehabilitation and Reablement review, the merger of the two main CCGs for Birmingham and proposed joint working agreements with NHS Sandwell and West Birmingham CCG were seen as opportunities to work more collaboratively. There had been a system level agreement that the BCF Commissioning Executive would act as the lead commissioning body for the Birmingham and Solihull STP across the interface of health and social care.
- The A&E Delivery Board scrutinised performance in relation to flow through the system. Meetings were attended by system leaders across the health and social care interface, but indicators used to measure performance were traditional and activity-focused rather than outcome-focused.

Risk sharing across partners

- There was limited evidence of risk sharing across partners within the Birmingham system, both in terms of operational risks and financial risks. While the recently completed Recovery, Rehabilitation and Reablement review was jointly commissioned and provided a useful diagnosis of part of the system where a collective response was required, formal risk sharing arrangements were not in place.
- Although organisations had their own systems and processes to identify and monitor risks, there was no shared risk register at an STP or Birmingham-wide level. System leaders should ensure they are able to appraise and assure themselves of those areas that present current and potential risks in order to mitigate them.
- Birmingham faced significant financial pressures; the local authority had seen a 30% reduction in funding and there was a large Cost Improvement Programme for the acute trusts. While these were widely acknowledged by system leaders, there was no sense these were considered a shared risk. Other than the section 75 agreement in relation to the Better Care Fund and Improved Better Care Fund (iBCF) there were no pooled budgets in place.

Information governance arrangements across the system

- There was clear intent from system leaders to facilitate the timely sharing of information between partners, but there were no clear or jointly agreed plans in place for this. Birmingham and Solihull's STP local digital roadmap had been judged to be a national exemplar by NHS England, NHS Digital and the Local Government Association. The local digital roadmap set out a list of proposals for the system to deliver the 2020 paperless agenda, but these had not been implemented.

- There was universal use of the NHS number across health and social care, but no shared care records, meaning staff could not access timely, up to date and accurate information. We were told about Your Care Connected, which aimed to give secondary care providers access to people’s GP records and allowed people to access their own health records. We were told that approximately 1.1 million people in Birmingham had opted-in to the service and, according to data collected by the system, secondary care record look-ups had increased from a monthly average of 1,836 between October 2016 and March 2017 to an average of 4,529 between October 2017 and January 2018. However, no frontline staff in either the acute or community setting referred to this facility when asked about sharing information, suggesting it was not widely used or understood.
- Staff in A&E and an out-of-hours GP provider told us they could not access GP records; the out-of-hours provider relied on information in Special Patient Notes and Summary Care Records, which were not available for every patient. Staff throughout the system reported that information sharing across the health and social care interface needed to improve and this was described as a key barrier to integrated working and improving outcomes for people.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

There was no single, coherent workforce strategy for the city of Birmingham; workforce planning remained at organisational level. While there was recognition and clear intent from system leaders to address this, at the time of our review this remained under-developed. There was a workforce strategy at STP level, but this needed to be translated to the local level at pace to ensure it was aligned to the vision for the community care model. The city faced some significant recruitment and retention challenges, but due to the lack of a strategic workforce plan, it was unclear how these were being addressed.

System level workforce planning

- There was not a single strategic workforce plan for Birmingham, which system leaders recognised and intended to address. Workforce development at an STP level was also in its infancy. While there was a BSol STP Workforce Strategy 2017-2021, developed through the Local Workforce Action Board and last reviewed in September 2017, this had not been built upon and there was limited evidence to demonstrate how it had been implemented. A workforce workstream had recently been established within the STP which was led by the Chief Executive of Birmingham and Solihull Mental Health NHS

Foundation Trust. However, this was at very early stage and had only met on two occasions to further develop a system-wide workforce strategy.

- Birmingham had participated in a collaborative workforce planning programme supported by Health Education England West Midlands and Skills for Health. However, this had not been acted on and at the time of the review workforce planning was based at organisation or sector level. System leaders hoped the recommendations from the Recovery, Rehabilitation and Reablement review would be a driver to think about future workforce planning. This needs to commence at pace and include a review of roles across the pathway to ensure a system-wide workforce strategy is aligned to the anticipated needs of the ‘constituency’ based model of care so there is sufficient capacity to meet demand.

Developing a skilled and sustainable workforce

- The recruitment and retention of GPs was identified as one of the greatest risks for the system. The GP consortiums had implemented a number of programmes to develop the primary care workforce, for example through GPs being able to specialise in areas of interest. An international recruitment programme to recruit 100 GPs over the next five years had been approved, run by a national scheme. However, at the time of our review the international recruitment had not yet started and there was uncertainty among primary care providers as to the status of this initiative, with some telling us it had been put on hold. This was out of the system’s control.
- Analysis of Skills for Care adult social care workforce estimates in 2016/17 showed that Birmingham had a higher turnover rate compared to its comparator areas (32.9% compared to 25.9%, up from 29.9% the previous year), but a lower vacancy rate (5.1% compared to 6.6%). We were told by the local authority of emergent plans to build the skills and capacity of the workforce; however it was recognised that there was scope to further support providers to develop a skilled and competent workforce.
- System leaders were working to develop the workforce through partnerships with local further and higher education institutions. However, the local authority reported that it lost a significant number of social workers to neighbouring boroughs once they had completed their training, owing to higher levels of pay offered.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners were providing a diverse and sustainable market in commissioning of health and social care services.

The JSNA was not fit for purpose and there was no annual public health statement, despite this being a statutory obligation. Commissioning activity had historically been reactive to pressure points within the system and while there was a recent drive to shift to community-based, preventative commissioning, strategies were embryonic and had been developed in isolation; there were no examples of joint commissioning. As a result, there was limited evidence of commissioners using strategic commissioning intentions to shape the market and work collaboratively with VCSE sector organisations. However, recent changes had led to a refocus of priorities and a renewed motivation to deliver improvements for the people of Birmingham.

Birmingham faced significant quality issues within the social care market, which needed to be addressed. It was hoped the newly developed, fixed-price framework would support this process, but commissioners also needed to consider how the online tendering process was impacting on people's choice and dignity.

Strategic approach to commissioning

- There was not a clear strategic approach to demonstrate how the visions of the two STPs were informing commissioning intentions for the city of Birmingham. A recently developed overarching vision focused on prevention and place-based care and £2.7 million per annum had been made available to implement a Neighbourhood Networks Scheme, to develop a community assets-based model. To date, however, the commissioning of preventative community services had been characterised by reactive cuts, short term contracts and a lack of engagement with providers. It was widely recognised by system leaders that the prevention agenda was underdeveloped and there had been an over-reliance on bed-based care for people who could be better cared for at home. Voluntary sector organisations we spoke with described how short-term, reactive funding had meant they could not plan future service delivery and created uncertainty. They were positive about the new Director of Adult Social Services and the changes that had begun to happen, but they were concerned by the fact the post was being filled on an interim basis.
- Needs assessments were not adequately driving strategic commissioning. This was an unfortunate omission at a time when the health and care system was undergoing seismic change and the needs of the population needed to influence and inform system wide strategic development, commissioning and planning. While there was a clear shift to a place-based commissioning model, at the time of our review strategies were still being reviewed, updated and developed and there was not a system-wide understanding of the population's needs or wants. We were told commissioning strategies would be informed

by the JSNA, but we found this document was out of date and did not provide the detailed assessment expected. There was no evidence to suggest it had multi-agency input and it did not appear to unite all other needs analysis for the place, including local economic assessment and skills assessment. Furthermore, no annual public health report had been published for the last two years despite it being a statutory obligation to do so.

- There was a newly developed commissioning strategy for adult social care and a high-level community commissioning strategy was being developed by BSol CCG, expected to be completed by the end of March 2018. Health and social care commissioners demonstrated willingness to work more closely together, but at the time of our review there were no meaningful joint commissioning arrangements in place and strategies were being developed in isolation. Furthermore, some staff we spoke with told us strategic commissioning was led from the top and was not sufficiently co-produced with operational staff, which was a missed opportunity as they were the ones who really understood the frontline issues.
- There was no strategic collaborative approach to planning and delivering services with VCSE sector organisations. For example, there was no forum for VCSE bodies to feedback to commissioners what needs they were seeing on the ground, or for commissioners to tell them where the gaps in services were. This was recognised by system leaders and commissioners and in November 2017 Birmingham City Council's cabinet had signed off a proposal which signalled a change in strategic direction and demonstrated a commitment to develop community assets.

Market shaping

- At the time of our review there was limited evidence of effective market shaping to ensure sufficient capacity, quality and innovation in terms of service provision and the workforce. Commissioning had been traditional and reactive, focused on services rather than outcomes in response to pressures within the system. There was a renewed sense of motivation and clear intent from commissioners to drive up quality and invest more in the VCSE sector, which was a positive step and needed to be embedded and translated into innovative commissioning activities.
- We were told by the Head of Commissioning for the local authority that the introduction of a new commissioning strategy and the retendering process, which would see fixed prices for care, were the beginnings of shaping the market in Birmingham. A 2018 Older Adults Market Position Statement had also been published shortly before our review.
- Birmingham had a challenging social care market with a high proportion of poor quality residential and nursing home care. Analysis of CQC ratings data showed that 33% of residential home providers were rated requires improvement and 5% were rated as

inadequate compared to the England averages of 15% and 1%, respectively. Thirty-four percent of nursing home providers were rated requires improvement and 2% were rated inadequate compared to the England averages of 25% and 3%.

- There were also challenges with the quality of domiciliary care. Twenty-six percent of Birmingham's domiciliary care providers were rated as requires improvement compared to comparator areas (13%) and across England (11%). None were rated inadequate as of December 2017. Birmingham had a high number of domiciliary care services per population aged 65+ (there had been a 15% increase between April 2015 and April 2017). Providers we spoke with told us that the market was "saturated", which was driving down the price and quality of domiciliary care.
- At the time of the review the local authority had issued a revised framework for domiciliary care with the intention of reducing the numbers of agencies that they contracted with from 147 to 111, with only providers offering a good standard of care registered on the framework. The framework would increase the focus on quality, with fixed fees for domiciliary care, as opposed to the price and quality split used within the existing micro tendering process.
- The local authority had developed a revised commissioning strategy, which stated that people who needed residential, nursing or domiciliary care would not be placed in a service rated as inadequate by CQC. This had been approved by the council's cabinet in December 2017, but was not due to be implemented until May 2018. From May 2018, the local authority commissioning team were intending to work with people already in inadequate rated services and their families to look for alternative placements. CQC inspectors reported there had been a definite shift in future commissioning intentions, which was positive, but stressed commissioners needed to respond more proactively and quickly to poor quality service provision.
- Birmingham has reduced the rate of older people admitted to permanent social care accommodation. Analysis of Adult Social Care Outcomes Framework (ASCOF) data for 2016/17 showed the rate of care home admissions for older people as 552 per 100,000 population in Birmingham, below national and comparator averages. The commissioning intentions for long-term care beds focused on beds for people with the most complex needs including dementia.

Commissioning services to improve the interface between health and social care

- Commissioning activity had been reactive, responding to particular pressure points within the system. A new approach to commissioning preventative services was being developed. This approach will include a review of the social care offer and of VCSE sector

assets; evidence based planning; review of multidisciplinary staffing capacity at the hospital front door; and seven day social care support.

- A new approach to commissioning was welcomed by VCSE sector representatives we spoke with, who had felt underutilised to date, and who thought that that commissioning and contract oversight was output rather than outcome driven. A commitment to the expansion of the Home from Hospital service, which supported people's discharge from hospital, was a positive development.
- Birmingham used an online micro-tendering system to procure long-term care. This system did not facilitate person-centred care and was in fact described by the Phyllis production (which used information collected from staff and people who use services) as "eBay for Grannies". Feedback from frontline staff and people who used services described the system as an auction site and included examples of when people had been "rejected" by providers or of packages of care being awarded to the lowest bidding service. Commissioners had not given consideration to the impact this had had on choice, dignity and person-centred care. Furthermore, there was a missed opportunity to use the information gathered through this system to understand the gaps in provision for people in Birmingham. We were informed following our review that a proposal to procure a new system had been approved by the council's cabinet in December 2017.

Contract oversight

- At the time of the review, the local authority was commissioning services that had been rated as inadequate and requires improvement by CQC; however there were plans to stop placing people in services rated inadequate from May 2018. The local authority carried out checks of residential and domiciliary care services on a reactive basis to gain assurance they were providing appropriate care and support.
- There were moves towards a more collaborative approach between the local authority and the CCGs to monitoring the quality of care provision. The CCGs and the local authority had developed a Joint Quality Assessment Framework that had been rolled out across nursing homes. There was an agreement between the local authority and NHS Birmingham CrossCity CCG for the CCG to carry out quality checks in nursing homes on behalf of the local authority.
- Health and social care providers we spoke with during our review told us that relationships between commissioners and providers had been poor, but had recently improved. However, we received mixed feedback from respondents to our relational audit with some, particularly social care providers, feeling the local authority still exhibited a lack of engagement, consultation and transparency.

- Historically there had been many complaints from dissatisfied families, providers and staff regarding continuing healthcare (CHC) processes. An audit was undertaken in October 2017 by an independent provider commissioned by the interim Accountable Officer of the shadow form BSoL CCG, which confirmed poor oversight and unsatisfactory outcomes provided by Arden and Greater East Midlands Commissioning Support Unit. Performance was particularly poor for those referred for fast track CHC, which is often used to enable people to return to their preferred place of care in the last days of their lives. It was acknowledged by the system that performance had been sub-optimal for two years and with agreement from NHS England the commissioners awarded a contract to an alternative CSU. While it was positive these actions had led to improvement, if there had been more scrutiny and contract oversight earlier, people may have been protected from unnecessary delays.

How do system partners assure themselves that resources are being used to achieve sustainable high-quality care and promoting peoples' independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high-quality care and promote people's independence.

Like much of the country, Birmingham faced significant financial pressures. We found there were robust controls and governance arrangements in place in relation to the Better Care Fund monies to provide assurance that available resources were being used in the most effective manner. However, other than the BCF there were no pooled budgets and it was acknowledged there had not been a high level of scrutiny. Focus had been primarily on finances rather than outcomes for people when setting budgets. There was acknowledgement that Birmingham needed to shift away from relying on bed-based care and focus on keeping people well in their own homes. The delivery of the STP's vision for place-based care and service transformation will be key to coping with increased demand and ensuring resources are being used to achieve sustainable, high-quality care.

- The system faced significant financial pressures; the improved Better Care Fund (iBCF) plan described a system-wide gap of £730 million to 2021. Historically there had not been a high level of scrutiny of the finance and budget setting process, which was acknowledged by some system leaders we spoke with.

- The delivery of the STP and service transformation (and related efficiency programmes) will be key to managing financial challenges and coping with increasing demand. The response to the SOIR described how additional investment had been made in new models of care and to increase capacity; it also outlined where savings had been made by the local authority, including by closing expensive in-house residential homes. System leaders acknowledged there had been a reactive, finance-focused agenda to service delivery in the past and there was a clear intent to move towards outcomes for people instead. There needs to be a review of Enhanced Assessment Beds (EABs), as identified by the Recovery, Rehabilitation and Reablement review. These were not being used effectively and were described by multiple system partners we spoke with as being a “reactive approach” to system flow issues.
- System leaders acknowledged there had been an over-reliance on bed-based care in the community. Our analysis showed that there were slightly higher residential and nursing home beds per population aged 65+ in Birmingham compared to comparator areas and the England average. Rates of admission to residential and nursing care homes to provide long term support for older people had decreased in 2016/17 to 552 per 100,000 from 663 per 100,000 the previous year and were below the England average and the second lowest out of 16 comparator areas. Avoiding permanent admissions can be a good measure of delaying dependencies and system leaders described a clear intent to support people to remain in their own homes. However, BCHT reported district nurses were seeing approximately 1,000 more people each week than they were commissioned to provide for. Representatives from the BCHT felt the value added by the district nurses to support people to remain well in the community had not been recognised, but they were working with commissioners to address this.
- With low uptake of personal health budgets and direct payments for social care, high numbers of people waiting to be discharged from hospital and a shortage of good quality nursing and specialist beds, the system needs to assure itself that resources are being used most effectively to ensure good outcomes for people.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in their usual place of residence

Are services in Birmingham safe?

There were opportunities to make care for people in Birmingham safer. There was not a system-wide approach to managing risk; individual GP practices had their own systems to manage risk, however these were not shared. There were signs that risks were not being appropriately managed in the community. Birmingham had a high rate of attendances at A&E and staff at the hospital front door saw people being admitted who should have been cared for at home.

Support from GPs into care homes varied across Birmingham. Routine medication reviews for people who were receiving domiciliary care were not taking place. However, there were good links between the prevention of hospital admissions and the local authority's housing strategy.

- There was scope to improve systems and processes in Birmingham so that people could be safely maintained in their usual place of residence. There was not a system-wide risk stratification tool to provide a single view of those who were at most risk of a hospital admission. Individual GP practices and federations were using the frailty index and maintained their own registers of patients, but there was no formal mechanism in place to share this with colleagues across health and social care.
- There were signs that risks were not being appropriately managed in the community. Our analysis of quarterly rates of A&E attendances for people aged 65+ between April 2014 and March 2017 showed that Birmingham had a consistently higher rate of A&E attendance per 100,000 population than its comparator group average and the England average.
- There were concerns among frontline staff we spoke with that professionals did not always have the confidence and support to manage risks, which led to avoidable attendances and admissions to hospital. Staff at the hospital front door told us they saw people at the end of their life admitted to hospital, when they could have been cared for at home – indicating a need for better coordinated community-based end of life care.
- There was not a system-wide model of enhanced GP support to care homes or district nurse input to care homes commissioned by Birmingham's CCGs. Some GPs provided support to care homes through privately arranged contracts. Our conversations with residential care providers confirmed a variable picture of support and access to primary care across the city. Our analysis of data between October 2015 and September 2016 showed that older people living in care homes in Birmingham had higher rates of admissions to hospital with conditions which could be treated in the community or avoided in the first place such as decubitus ulcers, pneumonia, pneumonitis and other lower respiratory tract infections compared to similar areas and the England average.
- Polypharmacy medicine reviews were not routinely taking place in the community and multidisciplinary team working including pharmacists was not consistent. Polypharmacy reviews took place in GP practices and care homes; however there was no input into

domiciliary care. There was not a robust risk assessment in place to review people who may be at increased risk of falls owing to their medications.

- Falls services were provided by BCHT across the city and people could be referred by their GP, by a family member or carer, or refer themselves. Falls assessments were carried out in the person's own home by a falls nurse assessor. There was some disjointed access to the service across the city. Within the east and north quadrants there were physiotherapists and occupational therapists who worked with people as part of the team. However, within the central and west areas a further referral was needed to access physiotherapy and occupational therapy services.
- The local authority recognised the links between housing, health and adult social care. The local authority's housing department was working proactively to support people remain safely in their own home. This included a review of sheltered housing to ensure it was appropriate, the introduction of a handyman service, and a visiting programme for local authority tenants, which included identification of safeguarding issues and potential care needs. All housing staff that came into contact with tenants received safeguarding training, including contractors.
- Birmingham's Safeguarding Adults Board had a wide representation of partner agencies, including groups representing people who used service and carers, and VCSE sector providers. However, we were told that not all NHS trusts fully engaged in the partnership meetings, so there was not a collective response to learning and improving from safeguarding concerns. This could undermine the effectiveness of the board's role to coordinate and continuously improve safeguarding activity across the system and protect people from abuse and neglect.

Are services in Birmingham effective?

There were opportunities to make services more effective across Birmingham to keep people well at home. We saw examples of innovative practice, such as primary care led integrated services; however these were not available across Birmingham, meaning that people were receiving unequal service provision.

Communication and information sharing between professionals was patchy. There was a 24/7 single point of access for community health services that was available to health and social care professionals, however not all were aware of it. The GP out-of-hours service had no access to GP records, hospital records or pathology and radiology results meaning that they were making decisions without access to all the information they needed to make comprehensive judgements about care and treatment. This was an unnecessary risk that needed addressing urgently.

- While services designed to support people to remain well at home were evidence-based, they were uncoordinated and fragmented. The range of services available from multiple providers throughout the city meant there was potential for duplication, but also inequity in service provision in some areas.
- The vision outlined by system leaders for place-based care in local communities was already in operation in some parts of the city, not as a system-led scheme but as a result of innovative local providers. For example, the Connected Care Partnership Vanguard was implementing a model of integrated primary and community based services to an entire population in Sandwell and west Birmingham. The model was underpinned by a 24/7 single point of entry, multidisciplinary community-based alternatives to hospital, and through empowering local people to manage their own care. The Vanguard was led by Modality Partnership, a long-established GP organisation providing primary care at scale. It built on Modality Partnership's model of a centralised triaging system and multidisciplinary working. There was however some uncertainty about the future of the Vanguard as monies for the programme would shortly be coming to an end and it was uncertain if the proposed localities of the STP were coterminous with the positive relationships they had developed.
- There was not an integrated single point of access for health and social care. A 24/7 single point of access, provided by the community trust, was available to health and social care professionals and people known to the service. The service provided advice and a multidisciplinary community team response. We received positive feedback from GPs that the service was effective in coordinating access to the right support when someone was at risk of entering a crisis. However, not all care professionals were aware that they could use the single point of access, and referral data for the service showed that very few referrals came from outside primary care. For example, in January 2018 the service received one referral from residential and nursing homes and one referral from the voluntary sector; by contrast 1999 referrals were received from GPs.
- The VCSE sector delivered a range of services across Birmingham that supported older people to stay well, socially connected and independent. For example, the Ageing Better Programme engaged hard to reach older communities through a hubs model. Age UK Birmingham, in partnership with NHS Birmingham CrossCity CCG, delivered a social prescribing model which had showed positive results after its first year.
- However, awareness of and engagement with VCSE services by health and care professionals was variable. There were good practice examples of primary care integration with the VCSE sector to respond to people's medical and social needs, such as the neighbourhood befriending scheme led by Karis Medical Group, but these were pockets of innovation within a large system. There was acknowledgement across stakeholders that further work was required to support and coordinate the preventative and low level service

landscape. Some prevention services had been decommissioned in recent years despite being evidenced-based, and service provision was variable across the city. In November 2017 Birmingham City Council's cabinet had signed off a proposal which outlined how it intended to develop community assets and included the extension of existing contracts to allow time for the redesign and commissioning activity to take place.

- There were not systems to support the effective sharing of information between services. The GP out-of-hours service had no access to GP records, hospital records or pathology and radiology results. Care home providers reported that a lack of information sharing across agencies could result in people at risk being missed by the system.
- NHS continuing healthcare Data from March to May 2017 showed that all three CCGs in Birmingham had a lower rate of uptake of personal health budgets and direct payments for all adults compared to the England average. ASCOF data also showed that Birmingham had a history of comparatively low uptake of direct payments for social care, with only 11.3% of people aged 65+ who use adult social care services receiving direct payments in 2016/17, below the comparator average of 17.1% and national average of 17.6%. This means that fewer people in Birmingham had the chance to exercise choice and control over their care and support.

Are services in Birmingham caring?

People who use services, their families and carers had mixed experiences of services to keep them well at home. VCSE sector services providing support and advocacy for people living with dementia and their carers were highly valued by the people who used them. However people's experiences of receiving domiciliary care were not always person-centred. National data showed that older people using social care services in Birmingham had been consistently less satisfied than in comparator areas and nationally.

- People had mixed experiences of receiving services. Analysis of ASCOF data showed that the percentage of older people using social care services who said they were satisfied with their care and support had been consistently lower in Birmingham compared to its comparator areas and the England average since 2013/14 and had declined over time, with only 53% saying they were satisfied in 2016/17 (compared to 60% across comparator areas and 62% nationally). People who use services, their families and carers told us that the domiciliary care they received to keep them safe and well at home was not always compassionate, caring or person-centred. People reported a lack of continuity of staff, missed appointments and staff not speaking the requested language of the person.
- We were told that people found it challenging to navigate the system and access information about the support available to them. Analysis of ASCOF data showed that the proportion of older people who using care services who found it easy to find information about support

had been consistently lower in Birmingham compared to its comparator areas and the England average since 2014/15, and was significantly lower in 2016/17 (at 66% compared to the national average of 75%). There were two online directories for Birmingham, but these were out of date (one was 12 years old). Staff in the Adults and Communities Access Point, who were the initial point of contact for people, reported they had created their own directory as a result.

- The Ageing Better Programme to reduce isolation and loneliness was targeted at diverse and hard to reach communities across Birmingham. The programme had four priority areas: supporting older carers; supporting the older LGBT community; supporting Tyburn, which has a high population over 80; and supporting Sparkbrook, where there are language barriers and cultural differences.
- ASCOF data for 2016/17 showed that carers in Birmingham reported poor experiences compared to the England average; they reported lower quality of life scores, lower levels of satisfaction with social care services, and fewer had as much social contact as they would like or found it easy to access information about support.
- However, we saw positive investments in carer support services. There was a single point of information and advice for Birmingham's carers provided through Forward Carers, an organisation that signposts to support as well as providing statutory carers assessments and direct support. The Dementia Information and Support for Carers (DISC) service, provided by Crossroads Care, had received CCG and BCF funding to expand to cover all four quadrants of the city. Users of this service told us that it provided a lifeline of support that included information and advice, advocacy and weekly carers groups. We heard from an older carer who had found it hard to access any support after her husband suffered a stroke, including through the GP. The DISC service supported her to access benefits and a personal budget, and showed her how to manage direct payments to pay for care and support.

Are services in Birmingham responsive?

There were multiple, complicated pathways into services and it was not easy for people or staff to navigate the system. While there were examples of collaborative working and innovative service delivery to respond to people's needs and prevent admissions to hospital, they were not universally available. Therefore, people were not always seen in the right place, at the right time by the right person.

- People who use services, their families and carers told us that it was difficult to navigate services in Birmingham and access the care and support they needed to stay independent and well. Staff we spoke with acknowledged there were multiple pathways and an overly

complicated system which was hard for professionals working in the system to understand, let alone people who use services.

- People had mixed experiences of accessing GP appointments. While some people reported they were able to access same day appointments, others had struggled. Some GP federations, such as Modality Partnership, ran a centralised appointment booking system. However, some people we spoke with reported that appointments had filled by the time they got through to the system. Analysis of data as at March 2017 indicated that there was less access to GP appointments outside of core contractual hours in Birmingham than across comparator areas or nationally.
- There were several GP-led and nurse-led walk-in centres (WIC) throughout Birmingham, which opened seven days a week and were well utilised. We visited one WIC in south Birmingham which saw over 60,000 people in 2017, and evaluation data showed that only around 3,000 of these were referred to A&E. Staff at another WIC told us attendances at the WIC had been impacted by people being unable to access GP appointments.
- Residential and nursing home providers also reported varied access to primary care. Some had struggled to get GPs to visit their home and register residents. Others received a regular and responsive GP visiting service that included weekly reviews. Like people who use services, care home providers reported that the centralised booking system at Modality Partnership could be a barrier to accessing same day appointments and we were told that this could lead them to call the ambulance service instead. Birmingham's rate of A&E attendance from care homes for people aged 65+ was broadly in line with comparator areas and the England average.
- Issues around gaining timely access to social services were raised by a range of stakeholders in the system. We were told that accessing social worker assessment and reviews could be challenging. Care home providers noted that the accessing social care through the duty social workers, rather than having named social workers, was not responsive or person centred.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Birmingham safe?

Initiatives to divert people from being admitted to hospital at a time of crisis had limited success. A&E attendances and emergency admissions of older people were consistently high in Birmingham, as were the bed occupancy rates in the main Birmingham hospitals, which compromised people's safety.

- There was an integrated community service to respond to people in a time of crisis and avoid attendance and admission to hospital – the seven-day Rapid Response Service that operated in partnership between health and social care. However, Birmingham's rates of A&E attendances for people aged 65+ from April 2014 to March 2017 were consistently higher than across comparator areas and England.
- The emergency admission rates for people aged 65+ over the same period were also consistently higher than the comparator and England averages, and had been significantly higher than the England average in each quarter from July 2015 onwards¹. This suggests a high conversion of attendances to admission. Birmingham had implemented multiple hospital front door initiatives to assess older people, identify those who could be supported in the community, and divert their admission.
- WMAS was proactive in raising safeguarding issues across the system where they saw risks to people's safety. However, some care home providers had expressed concerns that the ambulance service was overly zealous in making safeguarding referrals when being called to an emergency at a care home. This suggests a lack of shared understanding of risk across services, and the potential for building stronger relationships and trust across professional groups. We were told that staff rarely received feedback from safeguarding referrals, so there was limited opportunity to implement learning across the system.
- The two main NHS hospital trusts that serve Birmingham had a higher bed-occupancy rate than the England average. From March to May 2017, overnight, consultant-led bed occupancy was at 96% at Heart of England NHS Foundation Trust (HoEFT) and 97% at University Hospitals Birmingham NHS Foundation Trust (UHB). Hospitals with average bed-occupancy levels above 85% risk facing regular bed shortages, periodic bed crises and increased numbers of healthcare-acquired infections, and it is generally recognised that the quality of patient care and experience may be compromised.

¹ CQC analysis of Hospital Episode Statistics data

- Information sharing across professional and organisational boundaries was fragmented with issues raised around the transferability of DNAR (do not attempt resuscitation) documentation across the care pathway when a person is in crisis. Care home providers told us that when a resident enters the acute care system with one DNAR, they can return with a different one. GPs did not always receive updated DNAR documentation, which meant people's wishes about this important personal issue may not be understood by those involved in their care and placed them at risk of inappropriate treatment.

Are services in Birmingham effective?

Care for people at a time of crisis was not always effective meaning that people were admitted to hospital who could have been better cared for elsewhere. Individual initiatives to support admission avoidance showed promising results, however the implementation of different models across Birmingham meant that people did not get a consistent response from the system at a time of crisis.

- While there were systems in place to respond to people in a time of crisis, the Recovery, Rehabilitation and Reablement review of system pathways found that nearly a quarter of people admitted to hospital could have been better cared for elsewhere. Their findings suggested that awareness and effective use of the Rapid Response Service could be improved.
- Between August 2016 and July 2017 the proportion of 999 calls which were resolved by with telephone advice was consistently lower than the England average. However, the proportion of incidents attended by ambulance crew and managed without needing to transfer a person to A&E was consistently just above the England average from October 2016 to July 2017, meaning more people were prevented from attending hospital unnecessarily.
- Initiatives at the hospital front door were based around integrated multidisciplinary team working with the aim to manage risks and triage people away from being admitted. For example, The ADAPT model (Advanced Discharge Assessment Planning Team) based at City Hospital (SWBH) provided a seven day multidisciplinary team comprising social workers, therapists, nurses and doctors working to reduce unnecessary admissions and length of hospital stay. ADAPT could undertake social work assessments, signpost to support services, and put packages of care in place.
- Another model in use was the REACT (Rapid Emergency Assessment and Communication Team), based on short stay wards and assessment units at Heartlands and Good Hope hospitals. This team helped to prevent admissions by undertaking early assessments and putting support in place for people within 72 hours of arrival.

- Individual initiatives showed promising results, however the implementation of different models operating across Birmingham's hospitals meant that people did not get a consistent response from the system at a time of crisis. Even within the same trust there could be several assessment units with duplicated, overlapping roles. This caused confusion as there was a lack of clarity among staff about where to appropriately refer people to. Despite initiatives to place professionals with the right skills at the front door there was still a perception among some professionals that the level of seniority of medical staff in A&E was a contributing factor to delays and unnecessary admissions.

Are services in Birmingham caring?

We saw evidence of people being able to exercise choice about how they received care when in a crisis situation. However families and carers of people living with dementia told us that those close to them did not always receive compassionate care in a crisis, and we saw that people with dementia could be admitted to hospital and spend a long time there because there was not a more suitable place available. Carers could access the Carers Emergency Response Service, however only 20% of registered carers had signed up to use it.

- Our review of case notes showed evidence of people's choice and preferences being taken into consideration in the planning of their care at a time of crisis. For example, we saw that an assessment undertaken by the REACT social worker recorded the person's preference to not receive care and had involved their family in the discussion.
- Families and carers told us that people living with dementia did not always receive compassionate and dignified care when they were admitted to hospital. We visited a Clinical Decision Unit and found that the environment was dementia friendly; however, this was not consistent across all hospital sites.
- We saw evidence of people with high support needs being admitted to hospital and spending a long time there because there was not an appropriate care setting available for them. We saw records of one person with severe dementia who had been admitted to hospital with no acute medical need more than two months earlier. In that time they had been assessed and declined by five different nursing homes due to their high level of needs. They were still waiting for a suitable home to become available for them.
- Birmingham carers could access a free 48-hour Carers Emergency Response Service. The service provided up to 48 hours of care in the instance of an emergency or to enable them to attend a planned medical appointment. The service requires that carers are pre-registered- at the time of our review it was reported that just under 4,000 carers were registered with the service out of the approximately 20,000 carers who registered with Forward Carers.

- VCSE sector services supporting people in the community reported that they can lose contact with people who use services when they are admitted to hospital. Improved communication between hospital staff and community based organisations would enable greater continuity of care, wrapped around the person, to support and sustain their move back home.

Are services in Birmingham responsive?

Services were not always responsive to people's needs in a time of crisis. People needing an emergency GP appointment were not always getting access to a GP. When people attended hospital they waited long periods of time in A&E departments. People were admitted to hospital when this was not the right place for them; we saw examples of people being admitted with social needs because there were not responsive community based services.

- There were initiatives in place for people to be seen in the right place at the right time at a time of crisis; however pressures and blockages in the system meant that people were not always seen in the setting that was most suitable to their needs. Birmingham has a pressured urgent care system – in 2016/17 all three hospital trusts in Birmingham missed the four hour A&E expectation and performed worse than the England average².
- There was variation across the city for people at risk of entering a crisis who tried to access emergency GP appointments. Healthwatch Birmingham's report *Can patients with a clinical need access emergency GP appointments in Birmingham?* highlighted that people with a clinical need for an emergency appointment were not always getting access to primary care. This could contribute to older people entering into acute settings unnecessarily. The knock-on effect of pressure in primary care was felt in other parts of the system such as increased demand for the 111 and ambulance services.
- During our site visits and in conversation with frontline staff we found evidence of people being admitted to hospital with social rather than medical needs. People were admitted because of a lack of timely out-of-hours community support. For example, we were told of a man who was a carer for his wife with dementia, and both of them were admitted when he fell ill. We saw evidence of people admitted for general frailty, such was the case for a 93 year old woman who attended A&E. We heard of a person admitted because they didn't feel safe to return home following a burglary and there was not an alternative way to support him.

² NHS England data

- WMAS was working with hospital staff to improve handover processes and had recently appointed increased hospital ambulance liaison officer support to reduce delays and improve the level of care during a handover. However, transport could still be a barrier to people receiving responsive care. On our site visits we saw instances where people who had already waited in A&E for over four hours were waiting up to three and a half hours to be transported home, and two hours to be transferred to another hospital within the same trust.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: **step down, return to usual place of residence and/or admission to a new place of residence**

Are services in Birmingham safe?

Delayed transfers of care and high rates of emergency readmissions compromised the safety of older people in Birmingham at the point when they were returning home.

- Birmingham had long standing challenges with delayed transfers of care. Our analysis of monthly delayed transfers of care data going back to April 2015 showed that Birmingham had consistently higher rates of delayed transfers per 100,000 population aged 18+ compared to England and comparator areas. Figures for November 2017 showed that performance in Birmingham remained worse than nationally or across comparators, with an average daily rate of 18.3 delayed days per 100,000 population compared to 12.2 across comparators and 12 across England. Birmingham's Recovery, Rehabilitation and Reablement review found a large proportion of older people sampled were medically fit, but were delayed in leaving hospital. When a person's discharge from hospital is delayed it increases their risk of hospital acquired infection and they are less likely to be able to regain independence as a result of prolonged inactivity.
- The proportion of people discharged from hospital who are later readmitted as an emergency can indicate the safety and appropriateness of discharges. From April 2015 to March 2017, our analysis showed that Birmingham consistently had a slightly higher proportion of emergency readmissions for people aged 65+ within 30 days of discharge from hospital than its comparator areas and the England average. There was a perception among some professionals in community and residential settings that pressure within the acute system was resulting in some people being discharged before they were medically ready, and were therefore more likely to be readmitted.

Are services in Birmingham effective?

There was evidence of multidisciplinary team working and implementation of the high impact changes to support effective discharges from hospital. However, the success of these models had not been established across the system. There were widespread concerns about the effectiveness of Enhanced Assessment Beds (EAB) as a temporary setting that would enable people to regain their independence, with people in these beds who would have been better cared for elsewhere.

- There was evidence of multidisciplinary working in hospital sites across Birmingham to facilitate an effective discharge process. The Queen Elizabeth Hospital (UHB) discharge hub was an example of good multidisciplinary working through an established co-located team, daily multidisciplinary meetings and a hospital-embedded social worker. We also saw effective collaboration across professionals including with the voluntary sector, supported by co-location, at Good Hope and Heartlands hospitals (HoEFT).
- There was some evidence of health and social care implementing the high impact changes to reduce delayed transfers of care; however this was not established practice across the system. An occupational therapy led trusted assessor model had been rolled out at UHB following a successful pilot which saw a 47% reduction in the average time from referrals to discharge for simple packages of care. The model allowed occupational therapists to undertake assessments of social care needs and access the social care system, freeing up social care staff from assessments. On our site visit we saw evidence of occupational therapists effectively leading assessments.
- Across and within Birmingham's hospitals there were multiple pathways available to facilitate discharge, however these were not always effective, joined up or well-coordinated. Across the system there were particular frustrations with the process of transferring people to Enhanced Assessment Beds (EAB). There was a lack of clarity about EAB admission criteria. We were told that people with complex needs could be assessed for and denied an EAB multiple times, and that people could be assessed for an EAB even if there were none available. EAB assessments were seen as a contributor to delays. For example, at Good Hope Hospital we saw that of the 115 referrals to external EAB, only 53 (46%) were assessed within the 24 hour agreed timescale.
- There were concerns with the effectiveness of EAB as a model to support people's timely and effective return from hospital. We saw that some people were staying in EAB for longer than was agreed on their plan. This could be detrimental to their recovery as while in EAB people did not receive the therapy input needed to regain independence. One of the findings from the recent in-depth review of system flow was that the majority of people

who were sent to an EAB or intermediate care would have been better cared for elsewhere. We were told that these beds could be used inappropriately for people with complex needs in order to reduce pressure on the hospital system. Frontline staff and senior leaders acknowledged that the system had become too reliant on bed based care as a means of reducing delayed transfers.

- The online bidding system used to commission long term care was not facilitating an effective transfer from hospital into long term care. Long term care providers told us that limited information about the person was made available to them through the system prior to bidding for the placement. This could result in them accepting a placement only to find out later that they were unable to meet the person's needs. The provider would subsequently reject the referral and the process would be restarted.
- Effective information sharing between hospital and long term care providers enables a smooth and successful transfer of care, however evidence we gathered indicated that information sharing between professionals involved in the discharge process in Birmingham was variable. Thirty-four registered managers of social care providers fed back to us about the flow of discharge information from hospital³. Only six said they received a discharge summary 75-100% of the time. Responses were mixed with regard to the comprehensiveness of the information they received, and some free text comments explained that the volume and quality of information handed over could be dependent on the ward, team or individual in the hospital overseeing the discharge.
- There was scope to improve the effectiveness of Birmingham's reablement services. Analysis of ASCOF data for 2016/17 showed the proportion of people over 65 discharged from hospital who received a reablement service in Birmingham was broadly in line with its comparators and the England average. However, the proportion of older people who were still at home 91 days after discharge into reablement was lower in Birmingham (77.5%) than its comparator areas (80.2%) and the England average (82.5%).

Are services in Birmingham caring?

The continuing healthcare (CHC) assessment process was not working as it should for people, their families and carers. Difficult messages were not communicated to people in a sensitive way and there was a lack of explanation. People lacked choice in their placement with regard to EAB and domiciliary care providers. However, person-centred care was being delivered by Home from Hospital volunteers.

³ 18 registered managers of domiciliary care, 11 registered managers of care homes, three registered managers of nursing homes, two registered managers of services providing housing with care.

- Home from Hospital volunteers provided a person-centred service. For example, we were told about a case of a 90 year old woman who had lost confidence after falling and breaking her wrist. The volunteer made arrangements for her bills to be paid. They accompanied her on hospital visits and arranged a taxi service so that she could maintain her independence. Owing to her sight issues the volunteer ordered the woman's bills in large print, displayed her appointments prominently and installed 'day light' bulbs. The Home from Hospital service was equipped to meet specialist needs around dementia, mental health, homelessness and substance misuse.
- It was widely acknowledged that CHC processes were not working as they should for people in Birmingham. We were told of delays in fast-track CHC for people at the end of their lives which meant that people were dying in a hospital setting who didn't need to be there.
- We were told about a person with dementia and affected by multiple strokes who had their CHC funding removed following a routine review. At no point was their family provided with information or guidance about the CHC process or a key point of contact; decisions were poorly communicated, and there was no support from the CCG or local authority to identify options for when the funding was withdrawn.
- The online bidding system used for commissioning long-term care was uncaring and not delivering person-centred outcomes for people. Providers raised concerns about the lack of information provided about the person, and the perceived prominence given to price over quality and appropriateness of care. We were told that if a person receiving a package of care was in hospital for longer than 10 days they were placed back into the bidding system, even if that person had expressed a wish to stay with their existing care provider.
- People and their families were not always able to exercise their choice in care placements due to capacity constraints in the market. Choice was a contributor to delays in the system as people and families would reject placements which were across the city from their home. Professionals and families told us that people lacked choice in EAB placements, and people were offered placements even when accessibility for the family was poor. Choice could be further limited if the person had complex needs such as challenging behaviour or required end of life care. Positive aspects of the EAB were also identified in that they afforded families breathing space before finding a long term care placement and meant that assessments were not being undertaken in hospital.

Are services in Birmingham responsive?

Although there had been some recent improvement in the oversight and management of discharges from hospital, this was fragmented and it was not clear at the time of our review

how effective these initiatives had been at improving flow. People were not always being discharged home with support or to a new care setting such as a care home when they were ready, as there were not the services available to support them in the community. People were waiting for assessments in hospital and this was also contributing to delays.

- People did not always receive care in the right place, at the right time, during the process of returning home or to a new care setting. Between February and April 2017, the largest proportion of Birmingham's delayed transfers of care was attributed to 'awaiting nursing home placement or availability'. Frontline professionals also told us that a primary reason for delayed transfers of care was awaiting suitable placements, particularly for people with complex care needs including dementia. Waiting for completion of assessments, awaiting residential home placements, packages of care and further non-acute NHS care also contributed to delays. This meant that people's needs were not appropriately met in a timely and person centred way.
- We were told by frontline staff that people were waiting in hospital for CHC assessments. In Q1 2017/18 a higher proportion of CHC decision support tools were being completed in an acute hospital setting than the England average⁴. The in-depth review into system flow commissioned by Birmingham's partners also highlighted delayed transfers of care owing to CHC, prompting the CCGs to commission an independent review of CHC processes. This review had led to a focussed response, increased management oversight and action planning to improve performance .
- There was evidence of improved oversight of delayed transfers of care in pockets of the system to drive more timely discharges from hospital. The 'Red to Green Bed Days' system had been implemented across all acute hospital sites in Birmingham, providing a visual impetus to move people through the system. On the day we visited one ward they had seven 'Green' patients, meaning they were receiving care that contributed to their recovery, and 16 'Red' patients experiencing waits for necessary acute care actions as well as those who were medically fit for discharge.
- City Hospital (SWBH) had introduced a ward dashboard and weekly targets that demonstrated a focus on identifying an expected date for discharge (EDD) on admission. An EDD league table had been introduced and was updated weekly, identifying each consultant and their performance. City Hospital had also introduced a 'Consultant of the Week' to focus on management and leadership issues and act as a conduit with medical

⁴ NHS Birmingham CrossCity CCG (53%), NHS Birmingham South and Central CCG (42%) and NHS Sandwell and West Birmingham CCG (37%) compared to England average (27%). A high percentage of tools being completed in an acute setting can be seen as contributing to delays (source: NHS England).

staff. There was still progress to be made towards timely discharges, as although each ward should have been able to discharge one person in the morning this was not being achieved.

- Queen Elizabeth Hospital (UHB) provided a ‘QEHB@Home’ service that allowed people to remain under the care of their hospital consultant, but receive day-to-day treatment from a team of healthcare professionals in their usual place of residence. This service allowed for the earlier discharge of people who would otherwise have been waiting for assessments. HoEFT had also made considerable investment in 116 virtual care beds provided through the Supported Integrated Discharge service at Heartlands Hospital and Healthcare @ Home at Good Hope Hospital in order to reduce delays.
- A ‘Quick Discharge Service’ could put in place a care package within four hours and was reported to be improving the discharge process. There was however a concern that the Quick Discharge Service was a reactive rather than an integrated sustainable solution, picking people up because the enablement service was not responsive enough.
- Birmingham had an established city-wide Hospital from Home service to support timely, safe and effective discharges, funded by the local authority. The service was delivered by more than 70 volunteers, and operated out of Birmingham’s hospitals. It offered low-level support for up to 12 weeks after discharge from hospital, reducing delays to discharge and improving people’s chance of a sustained recovery at home. The service supported 460 people between July and September 2017.
- Although delayed transfers of care data for November 2017 did show a very slight reduction in delays, it was not clear at the time of our review how effective these initiatives had been at improving flow or how they had stood up to winter pressures.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Birmingham?

- Our review in Birmingham showed there is a clear intent from the system’s leadership to improve how people move through the health and social care interface. However, the reality for people is variable with fragmented services leading to disjointed care. There had been no history, or cultural tradition of joint working within Birmingham, so the recent improvements to relationships and organisational structures, while embryonic, were significant. However, for improvements to be realised at the front line, considerable work is

needed to develop a shared strategic vision and drive this forward through all levels of the system.

- At the time of our review there was no single clear vision which could be articulated across the system. This was acknowledged by system leaders and although there was an overarching agreement to drive towards community, place-based care, work was needed to implement and embed this across all partners to achieve effective partnership working at all levels. There was no joint commissioning strategy and limited evidence of commissioning plans being informed by public health and the needs of the population. There had been no annual public health report produced for several years.
- System-wide shared governance arrangements were at an early stage of development. There were some good local working arrangements around the management of the Better Care Fund and the Birmingham and Solihull STP Board had taken on a system leadership role. While this was a positive step forward, for the system to mature it will be important to clarify how statutory partner functions will be discharged under the new arrangements, and clarify the overall governance structure. In particular, the relationship between the STP Board and Birmingham Health and Wellbeing Board (HWB) needs to be urgently reviewed and strengthened to determine how the HWB will adopt a greater role in system leadership for Birmingham.
- It was widely acknowledged that relationships in the past had been challenging. However, it was reported by leaders and operational staff that recent changes had seen relationships improve and there was a renewed sense of motivation. However, some key posts were interim and the pre-existing challenges and fragility of the system should not be underestimated. Work will be required to ensure all partners have an equal voice in the system. With the shift to preventative, community-based care there needs to be more proactive engagement with the VCSE sector, care providers, primary care and the public to ensure there is collaborative working in the interests of the population's defined needs.
- There was not a strategic approach to managing and shaping the market. There was limited evidence available in the JSNA and commissioning strategies in use at the time of the review to inform commissioning decisions across Birmingham. We were told of plans to introduce new contracting arrangements for residential care and domiciliary care providers. These will go some way to addressing current problems, however people continued to be placed with services rated as inadequate and this was not due to be addressed until May 2018.
- While there had been good joint working on the use of the iBCF, the use of risk stratification to target resources at high-risk population groups and services was limited. There was some initial thinking among system leaders about moving to locality-based

budgets, but this was at a very early stage of discussion and the concept was not understood across the system. The uptake of direct payments and personal budgets in social care and health were below target, which reflected the wider issue of underdeveloped practice around user choice and control.

- There was a workforce workstream at STP level to begin system-wide workforce planning. However, at the time of our review, there was no integrated, coherent workforce strategy for Birmingham.
- There was universal use of NHS numbers across health and social care, but not digitally shared records. More than one million people had opted in to Your Care Connected, which aimed to give secondary care providers access to people's GP records and allowed people to also access their own health records. However, despite an increase in the number of monthly 'look-ups' it was not being used effectively or widely by staff in secondary care. Staff throughout the system reported that information sharing across the health and social care interface needed to improve and this was described as a key barrier to integrated working and improving outcomes for people.
- There was a shared commitment to pursue the prevention agenda, but service delivery was underdeveloped. Although we saw examples of strong multidisciplinary team working, these were not embedded to ensure they were system-wide. Multidisciplinary working in community teams was at a much earlier stage of development. Pathways were disjointed and there was evidence of 'silo' initiatives which were not leading to system-wide learning and communication around good practice. Birmingham has established at-scale GP provision which should be used as an asset to deliver locally based enhanced primary care to keep people well at home.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- System leaders should develop and drive forward a shared strategic vision for the future with a shared use of language, ensuring it incorporates all parts of the pathway and is a collaborative approach.
- Strategic planning should be co-produced with all stakeholders, including independent care providers and voluntary sector organisations, to ensure the diversity of Birmingham's population is reflected.

- Public engagement in shaping the future of the health and social care system in Birmingham needs to be strengthened with a systematic and joined up approach to involving people to ensure that Birmingham's diverse communities are engaged in the planning and delivery of services.
- The relationship between the Birmingham and Solihull STP Board and Health and Wellbeing Board needs to be reviewed and strengthened to ensure there is agreement and clarity around roles and responsibilities.
- There needs to be stability in the system leadership to build on recent improvements and collaborative ways of working.
- System leaders need to continue to address current performance issues and work together to implement the recommendations made following the jointly commissioned Recovery, Rehabilitation and Reablement review.
- There needs to be a shared understanding of the prevention agenda, ensuring this is based on a robust Joint Strategic Needs Assessment and up to date public health analysis, which reflects the diversity of Birmingham's population. Publication of an annual public health report is a statutory obligation and the system needs to ensure this is fulfilled.
- Organisational development work needs to be undertaken to break down organisational barriers, strengthen relationships, improve communication and ensure there is a shared understanding among staff of their role in achieving the strategic vision at an operational level.
- The health and social care landscape needs to be rationalised with clear points of access. However, the system needs to ensure there is a comprehensive evaluation of current services and ways of working throughout the city before wholesale changes are made which could demotivate staff and destabilise good practice.
- System leaders should develop a coherent workforce strategy for Birmingham.
- The local authority needs to ensure it continues to fulfil its statutory obligation under the Care Act 2014 and provide assurance there is capacity of good quality services within the social care market.

- There needs to be more proactive scrutiny and contract monitoring to prevent further performance issues, such as those identified in relation to continuing healthcare.
- The system needs to consider how the current online micro-tendering procurement system for social care support impacts on peoples' choice, dignity and person-centred care.
- The personalisation agenda should be developed with more people supported to access personal budgets and direct payments.
- There needs to be a review of the eligibility criteria and assessment process for the Enhanced Assessment Beds to ensure they are being used appropriately to meet people's needs.
- Improving the capacity for information sharing across the health and social care interface should be prioritised, as this is currently a key barrier to integrated working.
- A consistent approach to identifying high risk population groups and managing risks to people within the community should be developed across the city.